Laboratory and Pathology Payment Policy

Applies to the following Tufts Health Plan products:

- ☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)[1]
- ☒ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
- ☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

Applies to the following Tufts Health Public Plans products:

- ☒ Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)
- ☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
- ☒ Tufts Health RITogether (a Rhode Island Medicaid Plan)
- ☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting independent laboratory providers and providers rendering laboratory services.

During the rapidly evolving situation around COVID-19, Tufts Health Plan's Laboratory and Pathology payment policy for medically necessary testing of COVID-19 are documented on the Coronavirus (COVID-19) Updates for Providers page.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan covers medically necessary laboratory and pathology services, in accordance with the member's benefits.

GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting Provider Services.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO, Tufts Health Unify, Tufts Health Together or Tufts Health RITogether members.

Third Party Testing

Tufts Health Plan does not cover specimen collection and lab processing costs ordered by third parties, such as schools, courts, or employers, or requested by a provider for the sole purpose of meeting the requirements of a third party.

Urine Drug Testing

Tufts Health Plan provides coverage for urine drug testing when billed with the procedure codes outlined in the Urine Drug Testing Coverage Guidelines. Coverage is also provided for G0659 when billed in accordance with CMS guidelines.

Note: All urine drug tests should be performed at an appropriate frequency based on clinical needs. The frequency should be at the lowest level to detect the presence of drugs. Refer to the Drug Screening Payment Policy (for Tufts Health Together and Tufts Health RITogether) and the Urine Drug Testing Medical Necessity Guidelines for additional information.

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.
[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained.

Referrals are not required for most non-genetic testing laboratory or pathology services; however, a medical requisition form or prescription is required from the requesting provider to direct the member to the appropriate lab, as well as perform medically necessary services.

Genetic Testing for Commercial and Tufts Health Public Plans Products

In most cases, genetic testing requires prior authorization. Refer to the appropriate genetic testing medical necessity guidelines for more information.

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry-standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

- Append modifier 26 to indicate professional components and/or modifier TC to indicate technical components that require the use of a modifier whether in an office, inpatient or outpatient setting.
  Note: Procedures defined as professional or technical component only in nature do not require a modifier and therefore should not be billed with modifier 26 or TC. Refer to the CMS National Physician Relative Value File for additional information.
- Submit multiple same-day services on one line; the number of services/units should reflect all services rendered.

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable network contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For additional information, refer to the Professional Services and Facilities Payment Policy.

Compensation for procedures that are part of laboratory quality control are not covered by Tufts Health Plan.

Note: Contracting laboratories may have a capitation agreement with Tufts Health Plan for services to be performed for a specific provider unit.

Unless otherwise noted, the following reimbursement information applies to all Tufts Health Plans products. Note: Refer to the appropriate sections for additional laboratory and pathology compensation information specific to Commercial, Senior Products and Tufts Health Public Plans.

Benign Paroxysmal Positional Vertigo (BPPV)

Tufts Health Plan will not routinely compensate 80047-89398 (lab tests) if the only diagnosis on the claim line is benign paroxysmal positional vertigo.

Colorectal Cancer Screening Tests (DNA-based)

Tufts Health Plan will not routinely compensate 81528 (oncology colorectal screening) if billed under the following circumstances:

- Without a colorectal cancer screening diagnosis or if the member's age is greater than 85 years on the date of service.
- For members less than 50 years of age on the date of service

Diagnosis Limitations

Tufts Health Plan does not routinely compensate for the following:

- EGFR gene analysis, common variants if billed without a diagnosis of malignant neoplasm of the trachea, bronchus or lung, malignant neoplasm of the pleura, or malignant neoplasm of the brain
- PCA3 testing, BCR/ABL fusion gene, or JAK2 gene analysis if billed without an appropriate diagnosis for **Senior Products**

Drug Testing
Tufts Health Plan does not routinely compensate for more than the following within a 365-day period per member, as they exceed clinical guidelines[3]:

- 80305-80307, 80375-80377 (qualitative drug screen) if billed with any combination of more than 20 units
- G0480-G0483 (drug confirmation) if billed more than 10 units

Tufts Health Plan does not routinely compensate for urinalysis (81000-81003, 81005, 81099), creatinine (82570), pH; body fluid (83986) or spectrophotometry (84311) when billed with the following toxicology procedure codes:

- Presumptive drug screen (80305-80307)
- Definitive drug testing (80320-80377, 83992, G0480-G0483)

Tufts Health Plan does not routinely compensate presumptive (80305-80307) or definitive (G0480-G0483, G0659) drug testing when billed more than one combined unit per day.

Duplicate Services
Tufts Health Plan does not compensate duplicate claim lines reported by an independent laboratory when billed by a different Tax ID, any provider ID or any specialty.

Tufts Health Plan will not routinely compensate duplicate drug codes if the same code with the same units has been billed on a different claim by any provider for the same date of service.

Fecal Occult Blood Tests
Tufts Health Plan does not routinely compensate for 82270 or 82274 (fecal occult blood tests) if billed more than once in a period of three consecutive days.

Genetic Testing
Tufts Health Plan limits the coverage of genetic testing procedures for inherited conditions to once in a member's lifetime.

Tufts Health Plan does not routinely compensate for the following:

- Genetic testing procedures if billed with a Tier 1 molecular pathology procedure
- BRCA 1, BRCA 2, gene or full sequence analyses, common duplication/deletion variants or BRCA 2 gene or full sequence analyses when billed if any of these codes has been previously paid for the same date of service.

Genital Herpes Screening
Tufts Health Plan will not routinely compensate 86696 (antibody; herpes simplex, type 2) if billed for a member 13 years of age or older on the date of service and the only diagnosis is a screening diagnosis code.

Helicobacter pylori (H. pylori)
Tufts Health Plan does not routinely compensate for 78267, 78268, 83009, 83013, 83014, 86677, 87338, or 87339 if billed more than once every eight weeks (56 days) for **Commercial or Senior Products**.

Human Immunodeficiency Virus (HIV) Testing
Tufts Health Plan does not compensate for human immunodeficiency virus testing if billed without a covered diagnosis.

Human Papilloma Virus (HPV) Testing
Tufts Health Plan does not routinely compensate for the following:

- 87623 (infectious agent detection by nucleic acid [DNA or RNA]; HPV low-risk types)

[3] This does not apply to Tufts Health Direct, Tufts Health RITogether or Tufts Health Unify.

- 87624-87625, 0500T G0476 (HPV testing) under the following circumstances:
    - for a female member less than age 30 on the date of service if the only diagnosis is a screening diagnosis code
    - If billed more than once in a five-year period by any provider for a female member between 30 and 65 years of age on the date of service if the only diagnosis is a screening diagnosis code
- G0476 (HPV screening) under the following circumstances:
    - If billed and the member's age is less than 30 years or greater than 65 years on the date of service
    - If billed by any provider more than once every five years

Natriuretic Peptide
Tufts Health Plan will not compensate for natriuretic peptide if billed more than four times per year.

Nuclear Matrix Protein 22 (NMP22)
Tufts Health Plan does not routinely compensate for immunoassays for tumor antigen, qualitative or semi-quantitative if billed with nuclear matrix protein 22 (NMP22) for the same diagnosis.

Reduced and Discontinued Services Modifiers
Tufts Health Plan does not compensate for any laboratory panel code billed with modifiers 52 or 53.

Serum
Tufts Health Plan does not routinely compensate for aluminum (82108) or ferritin (82728) if billed more than once in a 90-day period and a diagnosis of ESRD is on the claim.

Surgical Global Services
Tufts Health Plan does not routinely compensate for the additional surgical service, procedure code 36415 (venipuncture), when billed with an office setting place of service, as the venipuncture is included as part of the global surgical package of the initial surgical procedure. Refer to CMS' list of 90-day surgeries for additional information.

Surgical Pathology Diagnosis Limitations
Tufts Health Plan will not routinely compensate surgical pathology gross & microscopic exams (88305, 88307 or 88309) if the only diagnosis on the claim line is any of the following:

- Appendix
- Cornea
- Gallbladder
- Ganglion cyst
- Hemorrhoid
- Hydrocele or spermatocele
- Polyp of stomach and duodenum

Vitamin D Testing
Tufts Health Plan does not compensate for the following:

- Vitamin D; 25 dihydroxy (82306) when billed without a requisite diagnosis code or if billed more than four times per year for the diagnosis of vitamin D deficiency for **Commercial and Senior Products**
- Vitamin D; 25 dihydroxy (82306) billed more than once per year and the diagnosis is not vitamin D deficiency for **Tufts Health Public Plans products**

Commercial Products
The following reimbursement information applies to Commercial Products only.

Incomplete Laboratory Panels
Tufts Health Plan does not routinely compensate for the following tests when submitted on the same date of service, as additional laboratory components of a panel are included in the price of the laboratory panel code itself:

- More than two basic metabolic panel procedure codes
- More than one of the following procedure codes (82040, 82247, 84075, 84450, 84155, 84460) when billed with a basic metabolic panel procedure code
- More than three comprehensive metabolic panel procedure codes

- More than two electrolyte panel procedure codes
- More than two hepatic function panel procedure codes
- More than three renal function panel procedure codes

In-Office Tests
Providers affiliated with a provider organization of a Commercial HMO member's PCP will be compensated a fee of $5.62 per test subject to the following limits:

- Providers will be compensated for one test for an adult member and up to three tests for a pediatric member (up to age 12) per office visit.
- Compensation will be subject to withhold at the contractual rate.

Providers not affiliated with a provider organization of a Commercial HMO member's PCP will be compensated in accordance with contracted rates. Physicians will be compensated in accordance with their contracted rates for non-HMO products.

Lipid Panel Testing
Tufts Health Plan does not routinely compensate for a lipid panel test more than two times within a 365-day period. Refer to CMS for more information.

Prostate-Specific Antigen Testing
Tufts Health Plan does not compensate for prostate specific antigen (PSA) testing more than once per year under the following conditions:

- The diagnosis indicative of lower urinary tract signs and symptoms by any provider.

Unless there is a change in the patient's medical condition. Refer to the CMS Internet-only manual for more information.

Preventive Services
Tufts Health Plan does not routinely compensate for a pap screening when billed with a preventive medicine service by the same provider on the same date of service. Refer to CMS for additional information.

Senior Products
The following reimbursement information applies to Senior Products only.

Germline Mutation Testing
Tufts Health Plan does not routinely compensate the following genetic biomarker procedures, as they are considered noncovered services: 81161, 81200, 81205, 81228-81229, 81243-81244, 81260, 81280-81282, 81291, 81302-81304, 81330-81331, 81410-81417, 81420, 81425-81427, 81430-81431, 81434, 81439, 81440, 81442, 81460, 81465 or 81470-81471.

Prostate Cancer Screening Tests
Tufts Health Plan does not routinely compensate G0102-G0103 (prostate cancer screening tests) for members under 50 years of age on the date of service.

Tufts Health Public Plans
The following reimbursement information applies to Tufts Health Public Plans products only.

Colorectal Cancer Screening
Tufts Health Plan does not routinely compensate 82270, G0104, G0106, or G0328 (colorectal cancer screening) when billed and the patient is less than 45 years of age on the date of service.

Gamma Glutamyltransferase
Tufts Health Plan does not routinely compensate 82977 (glutamyltransferase, gamma) when billed without a covered diagnosis.

Human Chorionic Gonadotropin
Tufts Health Plan does not routinely compensate 84702 (Gonadotropin, chorionic; quantitative) when billed without a covered diagnosis.

Lipid Testing
Tufts Health Plan does not routinely compensate 80061, 82465, 83718, 83721 or 84478 (lipid testing) when billed more than six times per year in any combination by any provider.

Prostate Cancer Screening Tests
Tufts Health Plan does not routinely compensate G0102 or G0103 when billed more than once every 11 months.

Prostate-Specific Antigen Testing
Tufts Health Plan does not routinely compensate 84153 (prostate specific antigen [PSA], total) when billed without a required diagnosis.

Prothrombin Time (PT)
Tufts Health Plan does not routinely compensate 85610 when billed without a covered diagnosis.

Thyroid Testing
Tufts Health Plan does not routinely compensate for 84436 (thyroxine; total), 84439 (thyroxine; free), 84443 (thyroid stimulating hormone) or 84479 (thyroid hormone uptake or thyroid hormone binding ratio) when billed without a covered diagnosis.

Travel Allowance for Specimen Collection from Homebound or Nursing Home Bound Patient
Tufts Health Plan does not routinely compensate P9603 or P9604 (travel allowance one way in connection with medically necessary laboratory specimen) when billed without 36415-36416, 36591-36592, 51701, G0471, P9612 or P9615 (specimen collection).

Tumor Antigen by Immunassay
Tufts Health Plan does not routine compensate the following when billed without a covered diagnosis:

- 86300 (immunoassay for tumor antigen, quantitative; CA 15-3 [27.29])
- 86301 (immunoassay for tumor antigen, quantitative; CA 19-9)
- 86304 (immunoassay for tumor antigen, quantitative; CA 125)

Urine Culture, Bacterial
Tufts Health Plan does not routinely compensate 87086, 87088 (bacterial urine cultures) when billed without a covered diagnosis.

ADDITIONAL RESOURCES

Outpatient Behavioral Health and Substance Use Disorder Payment Policy
Pharmacy Medical Necessity Guidelines: Opioid Dependence Medications
Preventive Services

DOCUMENT HISTORY

- November 2020: Reviewed by Committee; eliminated preventive services information; added Senior Products and Tufts Health Public Plans content;
- August 2020: Added third party testing content
- May 2019: Added claim edits for benign paroxysmal positional vertigo (BPPV), surgical pathology, and duplicate drug codes, effective for dates of service on or after July 1, 2019
- November 2018: Added claim edits for bacterial vaginosis screening; HPV testing; and presumptive and definitive drug testing, effective for dates of service on or after January 1, 2019
- August 2018: Added claim edits for genital herpes screening, human papilloma virus (HPV) testing effective for dates of service on or after October 1, 2018
- June 2018: Template updates
- May 2018: Added claim edit for DNA-based colorectal cancer screening, effective for dates of service on or after July 1, 2018; clarified urine drug testing compensation information
- April 2018: Clarified existing urine drug testing guidelines
- February 2018: Added claim edits for colorectal cancer screening tests, effective for dates of service on or after April 1, 2018
- November 2017: Added edits for duplicate claim logic for independent laboratory services, human papilloma virus (HPV) testing, urine validity and drug testing, and vitamin D testing effective for dates of service on or after January 1, 2018
- September 2017: Policy reviewed by committee; added pathology content to policy to combine
- July 2017: Added edits for screening for cervical cancer with HPV testing
- March 2017: Added urine drug testing codes G0480-G0483, G0659
- February 2017: Added clarification of age limit for pediatric in-office tests

- January 2017: Template updates. Added urine drug testing codes 80305-80307 effective for dates of service on or after January 1, 2017; removed inactive HCPCS codes G0477, G0478, G0479 (end-dated 12/31/2016) and G6058 (end-dated 12/31/2015).
- May 2016: Added previously implemented edits for HIV testing and prostate specific antigen; added genetic testing and laboratory claim edits, effective for dates of service on or after July 1, 2016
- January 2016: Deleted procedure codes G0431 and G0434 as they were end dated as of 12/31/15, added new codes G0479, G0477 and G0478, added new policies for genetic testing and laboratory procedures, effective April 1, 2016, template updates

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.